



## **PRESUMPTIVE ELIGIBILITY TRAINING VERIFICATION FORM**

Please complete and sign this form, keeping a copy for your records. You may scan and e-mail, fax, or mail this form to the address at the bottom of the form.

By completing and signing this form, I acknowledge I completed **Presumptive Eligibility training** for Healthy Montana Kids, Healthy Montana Kids *Plus*, Former Foster Care Children (to age 26), Parent/Caretaker Relative Medicaid, Pregnant Woman, and Breast and Cervical Cancer.

I understand that I must scan and e-mail **OR** fax **both** Presumptive Eligibility applications and the Proof of Temporary Coverage form to the State of Montana Human and Community Services Division no later than 5 days after making a determination of Presumptive Eligibility.

Within 5 days of determination, **SCAN** the applications and Proof of Temporary Coverage form, create a secure ePass account at <https://transfer.mt.gov>, and e-mail the documents to [HHSPresumptive@mt.gov](mailto:HHSPresumptive@mt.gov) **OR** fax the documents to 1-877-418-4533.

I agree to provide families with a copy of the completed Presumptive Eligibility application, the Proof of Temporary Coverage letter, information about how to access program benefits online, and a copy of the Application for Health Coverage & Help Paying Costs.

I agree to provide assistance with all applications **OR** make arrangements for such assistance as needed to ensure submission of applications to the State of Montana.

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Name (please print)

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Phone

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Email

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Facility

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Address

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Date of Training

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Signature